Supreme Court, U.S.
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No. 97-156

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1997

RANDON BRAGDON, D.M.D.

Petitioner,

v.

SIDNEY ABBOTT, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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I. IF DR. BRAGDON'S RISK ASSESSMENT WAS WITHIN THE RANGE OF REASON GIVEN THEN-CURRENT MEDICAL KNOWLEDGE, HE SHOULD NOT BE LIABLE.

Respondents and *amici* ("Abbott") seem to concede that if Dr. Bragdon's risk assessment was within the range of reason given then-current medical knowledge, then Dr. Bragdon should not be liable.[1] Their concession is implicit in their refusal to join the issue, attacking instead caricatures of Dr. Bragdon's position.[2] The lower courts, however, did not apply the standard for healthcare provider liability under title III urged by Dr. Bragdon. Instead, each applied a legal presumption that required him to do significantly more to survive summary judgment than raise a genuine issue of whether his risk assessment was within the range of reason given then-current medical knowledge. If it was error to apply these presumptions, the case should be remanded for the application of the correct standard.

Furthermore, Dr. Bragdon is *not* arguing courts should defer to individual dentists because they are experts.[3] The term "deference" can be

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[1] The American Medical Association (AMA) expressly concedes that dentists "need do no more—and no less—than make a medically reasonable decision . . . ." AMA Br. at 25.

[2] Resp't Br. at 42, 46-47, 49 (characterizing Dr. Bragdon's position as seeking deference to subjective, personal beliefs, *simpliciter);* Infectious Diseases Soc. of Am., et al., Br. at 23 (same); AIDS Action Council, et al., Br. at 28 (same).

[3] Dr. Bragdon did designate himself as an expert for trial. Abbott objected under Rule 702, and Dr. Bragdon responded that his training and experience as a dentist for 17 years qualified him under Rule 702 to give testimony on numerous issues. For summary judgment purposes, however, Dr. Bragdon did not claim that his own personal opinions are evidence of the objective range of reason, and the District

misleading. Dr. Bragdon is not asking the Court to defer to anybody or to decide ultimately whether there is a significant risk. The legal question for the Court is when may a dentist be liable for discrimination under the ADA. Dr. Bragdon's view is that (1) if a reasonable dentist could have concluded from then-current medical knowledge that the risk was significant, and (2) if he thought in good faith that the risk was significant, then he did not violate Ms. Abbott's civil rights.

It is also important to understand that although the quantification of a risk can be mostly objective and scientific, to decide whether it is "significant" requires a value judgment informed by political, policy, or even personal factors.[4] Very low identifiable risks that are difficult to estimate are often "significant" for health policy reasons,[5]

Court never ruled on Abbott's Rule 702 objection.

[4] *See* Barry Sullivan, *When The Environment Is Other People: An Essay On Science, Culture, and the Authoritative Allocation of Values*, 69 Notre Dame L. Rev. 597, 601, 643 (1994) (the "standard formulation of the [*Arline*] 'significant risk' test represents a[n] . . . attempt to fit normative pegs into factual holes").

[5] OSHA treats the "Klein study," cited by Infectious Diseases Soc. of Am., et al. Br. at 20 n.10, as evidence of a significant risk to dentists, though it found only one apparent occupational HIV infection among 1,132 dentists. 56 Fed. Reg. 64004, 64092 (Dec. 6, 1991) (Pet. App. 83a-84a). The estimated risk of HIV infection following *just one* percutaneous occupational exposure to HIV is 0.3%, or 3 expected fatalities per 1000 exposed, which is *three times* the level of risk deemed "significant" by the Court in *Industrial Union Dep't, AFL-CIO v. American Petroleum Inst.*, 448 U.S. 606, 655 (1980) (plurality). Health officials thought the risk of developing Guillain-Barre syndrome for vaccinees was significant, even though it was less than 1 in 100,000. Richard Neustadt & Harvey Fineberg, *The Swine Flu Affair* 69-73 (1978); Arthur Silverstein, *Pure Politics and Impure Science: The Swine Flu Affair* 117-119 (1981). Dr. Bragdon

and reasonable individuals may have differing personal risk tolerances.

By affidavits of Dr. Marianos, the CDC reached an implicit policy decision that the known risk to dentists (for no one denies there is a risk) is insignificant.[6] The CDC disclosed this position for the first time in private civil litigation, which came to Dr. Bragdon's attention when he obtained a copy of Dr. Marianos's January 7, 1995, affidavit filed in *United States v. Morvant*, 898 F. Supp. 1157 (E.D. La. 1995). Various other organizations now maintain in an amicus brief that the risk is "negligible" (Infectious Diseases Soc. of Am., et al., Br. at 19-22).[7] These decisions have not been "the product of open and complete analysis," relevant dimensions of the problem have been "suppressed without explanation," Sullivan, *supra*, note 4, at 664, and the lower courts have tried to resolve issues "without acknowledging their normative

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was keenly aware of these policy precedents. In addition, while Ms. Abbott offered her opinion that taking penicillin is "considered safe" (Mot. for S.J. at 16, filed Sept. 19, 1995), the article relied on by her expert states that the incidence of adverse reactions to penicillin is a "*significant* health problem." John Erffmeyer, *Adverse Reactions to Penicillin*, 47 Ann. Int. Med. 288, 288 (1981) (Ex. E of Sept 13, 1995 Aff. of Donald Craven, M.D.)(emphasis added).

[6] The policy directive is implicit to the extent Dr. Marianos avoids using the term "insignificant." The locution he prefers, which first appears in his *fourth* declaration (J.A. 283), is that "it is *safe* to provide routine dental care to patients with HIV . . . when universal precautions are utilized." Dr. Marianos understands, however, that the intended result of his testimony is the establishment into federal law of the policy that the risk is insignificant.

[7] *But see* Carol Chenoweth, et al., *Postexposure Chemoprophylaxis for Occupational Exposure to HIV in the Dental Office*, 128 JADA 1135, 1136 (Aug. 1997) (**occupational HIV risk to dentists characterized as "low," not negligible**, and stressing need for HIV postexposure plans).

character" by deferring to the CDC which has "no mandate to resolve normative issues." *Id.* at 685.[8]

Nevertheless, according to Abbott (U.S. Br. at 26), the best thing the Court can do is to follow the advice in *Chalk v. United States Dist. Ct.*, 840 F.2d 701, 712 (9th Cir. 1988) (Sneed, J., concurring):

> Confronted with some uncertainties about scientific truth, judges, perhaps above all others, should act on the basis of that which is known, or, where this is not possible, on the basis of that which those best qualified to speak say is known. . . . [W]e have no choice but to accept their version of the truth.

The fallacy here is the assumption that the Court should or must accept anyone's version of the truth as to whether there is a "significant risk." The proper role of the Court is not final arbiter of substantive national health policy, acting on its own or in conjunction with the AMA or CDC. Even if Professor Sullivan's ideal agency existed, the agency's policies could have the force of law only by express Congressional delegation, not judicial fiat. The limited role of the judiciary is to decide if Dr. Bragdon committed a civil rights violation. The Court can best advance this goal by remanding for

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[8] Professor Sullivan's makes many good points, but his critical theme is belied by his own uncritical, unspoken, and unsupported assumption that if his ideal, democratically accountable agency of experts considered all the scientific and normative issues involved, it would naturally decide the risk of occupational HIV transmission is insignificant. Professor Sullivan also wrongly assumes that the burden of proof on "direct threat" is on defendants. *See E.E.O.C. v. Amego, Inc.*, 110 F.3d 135, 143 (1st Cir. 1997).

application of the legal standard urged by Dr. Bragdon, which does not require any court to set substantive national health policy.[9]

II. DR. BRAGDON'S RISK ASSESSMENT WAS WITHIN THE RANGE OF REASON GIVEN THEN-CURRENT MEDICAL KNOWLEDGE.

Abbott asks the Court to find that on September 16, 1994 (1) there was a "consensus among public and private health authorities that [filling Ms. Abbott's cavity] posed no significant risk of harm to Dr. Bragdon if universal precautions were followed" (AMA Br. at 27); (2) Dr. Bragdon knew or should have known of such a consensus; and (3) no dentist could have reasonably assessed the risk differently. The record supports none of these findings, and certainly not the absence of disputed fact required for summary judgment.[10] As to relevant facts and inferences therefrom, please see pages 12-25 of Dr. Bragdon's petition reproduced in the appendix hereto.[11] Dr. Bragdon also wishes to highlight three additional points.

First, Abbott offers only two pieces of evidence that Dr. Bragdon knew or should have known of a private and public consensus as to the significance

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[9] The Maine Human Rights Commission (MHRC) misstates Justice Department guidelines concerning "direct threat." *Compare* MHRC Br. at 4 *with* 56 Fed. Reg. 35544, 35560 (July 26, 1991), *reprinted at* 28 C.F.R. pt. 36 app. B § 208.

[10] Even if officials had made it known there was a consensus (which they did not), does the mere announcement define the boundaries of reasonable risk assessment? If not, what analysis must health officials provide before courts should close the legal door on the possibility that a private person could reasonably disagree?

[11] By joining these issues, Dr. Bragdon does not concede the Court should reach them. (*See* Pet. Br. at 10-11)

of the risk: (1) the 1993 CDC guidelines on infection control for dentists (Pet. App. 181a-199a), and (2) the American Dental Association's (AmDA's) 1991 policy statement:

> Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection both for patients and dental personnel.

(J.A. 225) The language in the 1993 CDC guidelines does not support Abbott's conclusion (*see* Pet. at 21-22). The language in the AmDA's policy statement is non-committal at best. To say that procedures provide protection and something may be done safely with proper precautions does not mean the risk is insignificant. Brain surgery may be done safely with proper precautions.

Furthermore, the contemporaneous opinion of the American Association of Orthodontists was that in health care settings "scientific evidence indicates that HIV disease poses a direct threat and significant risk" and "much uncertainty surrounds what precautions, including barrier techniques, if any, can prevent the transmission of HIV disease."[12]

Consider too the 1992 FDA guidelines to blood banks. (Pet. App. 97a) If Dr. Bragdon had contact with the blood of *any* patient in the preceding year because of a sharps or needlestick injury (which

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[12] Comment No. 863 at 5 (April 23, 1991) in ADA Comment Book #1 for Public Inspection, available through Justice Department, disability rights division, 4th floor, 1425 New York Ave. N.W., Washington, D.C.

always occurs more than once a year), and the blood bank followed the FDA guidelines, it would regard Dr. Bragdon as if he had HIV and not permit him to donate blood. According to Abbott this would make him disabled under the ADA (i.e., regarded as having HIV). If Dr. Bragdon sued the blood bank under title III, and it said he posed a direct threat, what result? Based on FDA guidelines, could no reasonable blood bank think the risk to dentists was significant? And if the blood bank may deem the risk significant, why not the dentist himself? Also, if the consensus was that the risk is negligible with universal precautions, why does OSHA mandate extensive and expensive *post-exposure* HIV testing and prophylaxis procedures for dental offices? *See* 29 C.F.R. § 1910.1030(f)(3)(ii)-(vi); 56 Fed. Reg. at 64064-65 (noting the "relatively high frequency of occurrence of exposure incidents" in the dental office).[13]

Second, Abbott's substantive analysis is essentially predicated on one sentence: The CDC has never documented a case of occupational transmission of HIV to a dentist. To maintain this argument, Abbott overlooks the CDC's warning

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[13] OSHA said available information was insufficient to estimate the effectiveness of universal precautions (UPs) in reducing occupational HIV infection. 56 Fed. Reg. at 64055. As for hepatitis B virus (HBV), OSHA estimated that UPs were only 75% effective, *id.* at 64058, and concluded that UPs are insufficient to provide the level of workplace safety mandated by law, *id.* at 64088. *See also* M.A. Noble, et al., *Hepatitis B and HIV Infections in Dental Professionals*, 57 J. Can. Dent. Assoc. 55, 55 (1991) ("use of gloves did not show a protective effect" and "[r]eliance on gloves for operator protection appears to be inadequate"). Like HIV, HBV is a bloodborne pathogen. Although HIV is about 100 times less infectious than HBV, HIV is more than 50 times as deadly. 56 Fed. Reg. at 64009 and J.A. 179.

that its figures "most likely [do] not reflect the full extent of occupational transmission" (Pet. App. 105a). She also discounts seven HIV-infected dental workers who had occupational exposures to HIV, and who "have been investigated and are without identifiable [non-occupational] behavioral or transfusion risks" (Pet. App. 111a n.3, 110a, 106a) (e.g., AMA Br. at 11-12). Abbott's handling of these dental workers illustrates the principle that "risk assessors make constitutive value judgments whenever they follow one methodological rule rather than another." Sullivan, *supra*, note 4, at 650. More concretely, Dr. Marianos's testimony that "it is likely that a number of [the seven dental workers] . . . actually had nonoccupational risk factors . . . they did not report or recognize" (U.S. Reply Mem. on S.J., Ex. A ¶ 5), shows that his value system leads him to speculate that all seven were infected while they or others carried on illicit sexual affairs or drug use hidden from CDC investigators.[14]

Third, Abbott never objected to the admissibility of Dr. Kuvin's expert testimony, unlike disputed expert testimony in *General Electric v. Joiner*, 118 S. Ct. 512 (1997). Without ruling it inadmissible, the Appeals Court tried to discount Dr. Kuvin's testimony because it relies

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[14] The Court must appreciate Dr. Bragdon's profound frustration when courts belittle his evidence as "conjecture" (even his direct observations of how often he sustains accidental sharps injuries! -- *see* Pet. App. 28a), and treat the sketchiest of public health official affidavits as gospel. Abbott also implies that the law expects dentists to take greater risks than patients or other citizens. This moral principle has never been part of our jurisprudence, and certainly not for elective, non-emergency treatment. *See, e.g., Le Juene Road Hosp., Inc. v. Watson*, 171 So.2d 202, 203 (Fla. App. 1965); *see also* 42 U.S.C. § 1395dd.

partly on post-September 1994 authority. But most of Dr. Kuvin's authorities pre-date September 1994.[15] Moreover, no one argues that anything happened after September 1994 to make it reasonable to assess the risk as significant when before it was not. Dr. Kuvin's opinion is plain that both before and after September 1994 Dr. Bragdon could have reasonably assessed the risk as significant. Dr. Kuvin's testimony, by itself and with the primary authorities cited by Dr. Bragdon, raises a genuine issue of whether Dr. Bragdon's risk assessment was within the range of reason given then-current medical knowledge. Weighing this evidence belongs to the fact finder at trial.[16]

III. DR. BRAGDON DID NOT REGARD MS. ABBOTT AS DISABLED.

Abbott makes two arguments under the third prong, 42 U.S.C. § 12102(2)(C), whereby a person

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[15] *See* Def.'s Rule 19 Statement of Undisputed Mat'l Facts, Ex. C; Second Decl. of Sanford F. Kuvin, M.S., M.D., D.T.M. & H. The reason no attempt was made in the District Court to divide Dr. Kuvin's opinions by the date of authority relied upon is that Dr. Bragdon proceeded as though the fact finder had to decide whether there is a direct threat. Dr. Bragdon argued on appeal for a standard based on reasonable judgment and then-current medical knowledge. The Appeals Court reached this issue over Ms. Abbott's objection.

[16] Filling cavities, which entails giving oral injections to nervous patients, working in bloody aerosol mists (Pet. App. 69a-70a), and poking with sharp instruments in bloody mouths, is a long way from the classroom setting, *cf. Thomas v. Atascadero Unified Sch. Dist.*, 662 F. Supp. 376 (C.D. Cal. 1987), and more like instruction in hard-style karate where "students frequently receive nosebleeds and minor cuts." *Montalvo v. Radcliffe*, No. 3:97cv487, Findings of Fact and Conclusions of Law at 2 (U.S. Dist. Ct. E.D. Va. Jan. 29, 1998) (finding that HIV-infected student posed direct threat to others in karate class).

is "disabled" if she is regarded as "having *such* an impairment" (emphasis added), meaning an impairment "that substantially limits one or more major life activities," 42 U.S.C. § 12102(2)(A).

The first is that she "is a person who is 'regarded as' having a physical impairment and therefore . . . a person with a disability under the statute." (Resp't Br. at 41) According to this argument, merely to regard an individual as having a physical impairment makes the individual disabled under the ADA. This eliminates from the inquiry the qualifying phrase "that substantially limits one or more major life activities."

The ADA's definition of "physical impairment" is extraordinarily broad. *See* 28 C.F.R. § 36.104 (physical impairment means "*Any* physiological disorder *or condition*, *cosmetic disfigurement*, or anatomical loss affecting one or more of the following body systems: [comprehensive list of all body systems]") (emphasis added). For Abbott, then, if a defendant regards someone as having a physical impairment (e.g., an infected finger or sprained ankle), the person is "disabled" under the ADA. This is over broad. *See* 56 Fed. Reg. at 35549, *reprinted at* 28 C.F.R. pt. 36 app. B § 104 ("simple infected fingers" are not disabilities, and "broken legs" are rarely regarded as disabilities). As the Justice Department explains, "Test C--Being Regarded as Having Such an Impairment" is intended to cover "persons who are treated . . . as having a physical or mental impairment *that substantially limits a major life activity.*" *Id.* at 35549-35550 (emphasis added).

Abbott also makes the somewhat narrower argument that for certain stigmatizing impairments, defined as those "which invoke fear and discomfort in others" (Resp't Br. at 40), a person is disabled when a defendant treats her

unreasonably out of unfounded fear, prejudice, attitudinal barriers, or the like. The essence of this argument is that whenever a defendant employer or public accommodation treats someone unreasonably based on exaggerated fears or discomfort concerning any impairment, the defendant, by virtue of that very act, *both* constitutes the person as having a stigmatizing disability and discriminates against her in violation of the ADA. This argument not only eliminates the inquiry into substantial limitation on a major life activity, but also collapses the distinction between determining (a) whether someone is disabled and (b) whether there was unlawful discrimination: an unreasonable reaction based on an impairment makes the plaintiff disabled and violates the ADA.[17]

This is an interesting theory, but even the Court's broadly worded dicta in *Arline* seems to recognize that the third prong is not satisfied for "those who are [merely] regarded as impaired," unless "as a result, [they] are substantially limited in a major life activity." *Arline*, 480 U.S. at 284; *see also* S. Rep. No. 93-1297, 93rd Cong., 1st Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 6373, 6414 (the new definition "focuses on substantial limitations of one or more of an individual's major life activities" and includes "an individual who is *regarded* as having such a substantial limitation"). This is sensible since otherwise the ADA would be transformed from the Americans with Disabilities Act into the "Act to Outlaw All Unreasonable Fears Based on Physical or Mental Impairments."

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[17] Here, contrary to Abbott's assurances, "the breadth of the definition [of disability]" is *not* "balanced by the limiting or restrictive principles in the substantive discrimination provisions." (Resp't Br. at 16 n.19)

The AMA implicitly recognizes that Abbott's arguments have no basis in the statute. The AMA therefore makes the novel argument that Dr. Bragdon regarded Ms. Abbott as substantially limited in the major life activity of caring for herself. Assuming only for the sake of argument that "caring for one's self," 28 C.F.R. § 36.104, includes periodic trips to have cavities filled,[18] the record does not support a finding that Dr. Bragdon's reaction caused Ms. Abbott to be substantially limited in the ability to care for herself, or that Dr. Bragdon perceived her as substantially limited in the ability to care for herself. Rather, Dr. Bragdon testified that when he offered to fill Ms. Abbott's cavity in a hospital, he believed that Eastern Maine Medical Center ("EMMC") "maintained [dental facilities] and general dentistry could be done at that facility without any problem" and EMMC would have been the "first place" he would have looked to if she had accepted his offer (June 5 and 6, 1995 Bragdon Dep. at 286-287, 282-283). EMMC is located less than 1.2 miles from where Ms. Abbott lived in Brewer and less than 1.1 miles from where she worked. (J.A. 48) Dr. Bragdon's office is three times as far away.[19] Dr. Bragdon did not,

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[18] "Caring for one's self" usually refers to *daily* activities such as bathing, dressing, cleaning, cooking, etc. *E.g.*, CDC, *Prevalence of Mobility and Self-Care Disability—United States, 1990*, 42 MMWR 760 (Oct. 8, 1993); *Nicely v. Rice*, 1992 WL 403091, *3 (D. Kan.).

[19] Dr. Bragdon also said he would have considered using St. Joseph Hospital (Bragdon Dep. at 282). St. Joseph is less than a mile from where Ms. Abbott worked. It was only after Ms. Abbott declined his offer that Dr. Bragdon learned that the head of dental services at EMMC and St. Joseph was against the idea of general dentists working in the hospital. (*id.* at 283-85) Thereafter Dr. Bragdon applied at Downeast Community Hospital in Machias for dental privileges, but

therefore, regard Ms. Abbott as substantially limited, or cause her to be substantially limited, in the ability to care for herself.

This evidence is also important because Abbott repeatedly accuses Dr. Bragdon of violating his ethical duty by *refusing* to treat her. Dr. Bragdon never refused to treat her. He decided to treat her, and said he would treat her in a hospital, which he thought would be EMMC. She said she would "think about it and get back to him" (Pet. App. 80a). Instead of responding to him, she sued him. In no way is it fair to depict this as a violation of Dr. Bragdon's ethical duty to treat.[20]

IV. ABBOTT'S INTERPRETATION OF THE TERM "DISABILITY" IS POLICY-DRIVEN, OPEN-ENDED AND NOT BASED ON THE STATUTE.

Dr. Bragdon agrees that the definition of disability is not limited to "traditional handicaps" such as blindness. That is why a person with TB, HIV, malaria, a drug addiction, any form of cancer, or any other "physiological disorder or condition, cosmetic disfigurement, or anatomical loss," 28 C.F.R. § 36.104, may and often will be "disabled" *as long as* that impairment also substantially limits a major life activity, or she has a record of such a limitation, or she is regarded as having

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ironically that failed mostly because Ms. Abbott was suing him and the hospital was worried about its own potential legal exposure. (Def.'s Mot. for S.J. Ex. 6)

[20] Deferral of elective dental and medical treatment to a safer, more controlled, or more convenient time or location is common. *See, e.g.*, James A. Cottone, et al., *Practical Infection Control in Dentistry* 81-82 (2d ed. 1996) (deferral of elective dental treatment whenever there is any reasonable uncertainty surrounding the possibility of active TB). As to more controlled settings, *see also* confidential document lodged with the Court.

such a limitation. This definition was formulated to "provide sufficient latitude (but still not be totally open ended)." S. Rep. No. 93-1297, 93rd Cong., 1st Sess., *reprinted in* 1974 U.S.C.C.A.N. 6373, 6413.

Abbott tries to fit asymptomatic HIV infection into this definition by exaggerating the uniformity of physiological and psychological responses. For some the diagnosis of HIV infection is so devastating psychologically as to substantially limit the ability to learn (e.g., go to school) or work (e.g., clinically depressed). But this is not universal. Physically, five percent of persons with HIV have "remained *clinically healthy* and *immunologically normal* for more than a decade," while the average interval between infection and the development of AIDS is about ten years.[21] Ms. Abbott herself reported that her "general health" was "good" (J.A. 49). When asked whether she was impaired in her ability to carry out *any* of her life functions by the fact she is HIV positive, she said "No" (J.A. 14). Psychologically, some with HIV have "indicated personal growth as a result of having this disease and were firm in their belief that this growth would not have happened without HIV as an impetus."[22] Everyone in one study "described being able to look to the future and acknowledged they are surviving with HIV infection and not waiting to die." Katz, *supra*, note 22, at 54. "Many of these individuals stated they would not change

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[21] Yunzhen Cao, et. al., *Virologic and Immunologic Characterization of Long-Term Survivors of [HIV] Type 1 Infection*, 332 N. Eng. J. Med. 201, 201 (1995) (emphasis added); Mitchell Katz, et al., *HIV Infection*, Current Medical Diagnosis & Treatment 1204, 1208 (1998).

[22] Anne Katz, *Gaining a New Perspective On Life as a Consequence of Uncertainty in HIV Infection*, 7 J. Ass'n of Nurses in AIDS Care 51, 53 (July-August 1996).

anything about their life, even the fact of their HIV infection." *Id.* at 58.[23] Accordingly, even the Justice Department agrees that the determination of whether any particular impairment (e.g., a severe allergy) is a disability "*must* be made using *the same case-by-case analysis* that is applied to *all* other physical or mental impairments." 56 Fed. Reg. at 35549, *reprinted at* 28 C.F.R. pt. 36 app. B § 104 (emphasis added). There is no special statutory exception for HIV in the ADA.[24]

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[23] *See also* Judith Rabkin, et al., *Stability of Mood Despite HIV Illness Progression in a Group of Homosexual Men*, Am. J. Psychiatry 154:2 at 231, 237 (1997) (compared to the "HIV-negative men, the HIV-positive men had slightly more anxiety and somatic depressive assessments," but "were not, by and large, clinically anxious or depressed"). *Amici* AIDS Action Council, et al., also considerably overstate CDC guidelines about things such as the danger of tap water. *Compare* AIDS Action Council, et al., Br. at 25 *with USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected With [HIV]: A Summary*, 44 MMWR, No. RR-8, 8-9 (July 14, 1995) *and Cryptosporidiosis: A Guide for Persons WithHIV/AIDS*, http://www.cdc.gov/ncidod/diseases/crypto/hivaids.htm (Feb. 11, 1998).

[24] By contrast, many States have laws that apply specifically to those with HIV. *See, e.g.*, Haw. Rev. Stat. § 515-6 (restrictive covenants void based on "race, . . . disability, age, or HIV"); Ill. Ann. Stat. ch. 20, § 301/30-5(aa) (Smith-Hurd) (discrimination prohibited based on "HIV status"); Ky. Rev. Stat. Ann. § 207.135(1) (Baldwin) (same); La. Rev. Stat. Ann. § 22:228 (West) ("terminal, incapacitating, or debilitating condition" includes "HIV"); Md. Code Ann., Health Occ., § 4-315(a) (dentists may not discriminate based on "HIV"); Mo. Ann. Stat. § 191.699 (Vernon) (health care professionals may not discriminate based on "HIV infection"); Mont. Code Ann. § 50-5-105 (same); N.J. Stat. Ann. § 10:5-5(q) (West) ("Handicapped shall also mean suffering from . . . HIV infection"); Vt. Stat. Ann. tit. 3, § 961 (unlawful to discriminate based on positive "HIV-related blood test"); W. Va. Code § 30-36-18 (1966) ("HIV" discrimination prohibited). Many of these laws directly regulate health care professionals. Because this field is traditionally occupied by the States, *see Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985); *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748, 772 (1976) (Burger, C.J., concurring), the Court should hesitate to interpret the ADA as a national health care regulatory act giving the force of law to implicit CDC guidelines.

Abbott also argues that everyone with a "serious, irreversible, life-threatening medical condition" (AMA Br. at 21) or a "contagious, incurable, fatal" condition (Resp't Br. at 28) is disabled. The theory is that the duration of life is substantially limited, and therefore all major life activities, whatever they are, are substantially limited. This view does not comport with the historical context, purposes, and language of the ADA, which are directed at persons with *past* or *present* functional limitations, not statistically probable future limitations, or even present conditions causing significantly shortened life-expectancies. *E.g.*, 29 C.F.R. pt. 1630 app. § 1630.2(h) ("impairment" under the ADA does *not* include "predisposition to illness or disease"). Many people by genetic predisposition or other condition (e.g., cancer, nicotine addiction, obesity) have significantly shortened life-expectancies. The ADA expands on the traditional idea of "handicap" by covering such individuals, but only if they have a record of a past or present functional limitation which is substantial, or are regarded as such.[25]

Congress could have passed the "Americans

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[25] This is one reason why statistics that 8% to 25% of the offspring of HIV-infected women have significantly shortened life expectancies do not make all fertile HIV-infected woman disabled, even if reproduction were a major life activity. Nor, contrary to the logic of Abbott's argument, would a nicotine addict's and/or functioning alcoholic's decision not to become pregnant make her disabled, even though "drug addiction and alcoholism" are impairments listed in 28 C.F.R. § 36.104.

with Terminal Illnesses Act," or the "Americans with HIV Act," but it did not. Even if every member of Congress wanted, expected, or assumed that HIV is always a disability, the objective import of the words in the statute does not support that interpretation. *See* Laurence Tribe, *Comment*, in *A Matter of Interpretation* 65, 65 (1997) ("[l]ike Justice Scalia, I never cease to be amazed by the arguments of judges, lawyers, or others who proceed as though legal texts were little more than interesting documentary evidence of what some lawgiver had in mind"); Ronald Dworkin, *Comment*, *id.* at 118; *see also Yellow Freight Systems v. Donnelly*, 494 U.S. 820, 826 (1990).[26]

Abbott also protests that it makes no sense to protect people with advanced "visible" HIV, but not asymptomatic HIV. The same can be said for almost every other condition: Why protect those who are substantially limited, but not those who are not quite as limited? It is simply inherent in the definition chosen by Congress.[27]

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[26] Dr. Bragdon is confident that an inquiry into why socially conservative opponents of the ADA maintained that all HIV carriers would be covered would disclose a purely political motive to exaggerate the ADA to make it look bad for their constituencies and to try to throw a late public relations obstacle in its path. *Cf. Gulf Offshore Co. v. Mobile Oil Corp.*, 453 U.S. 473, 483 (1981). Legislators on the other side hoped to accomplish their goal without having to amend the statute, since that could be difficult (i.e., if HIV, why not cerebral palsy, Huntington's disease, cancer, etc?). Thus, despite intense lobbying from AIDS organizations and a direct recommendation from the Presidential Commission on HIV to clearly include HIV as a disability, a majority in Congress (if it existed) lacked the courage of its convictions, settling for floor speeches and ambiguous committee reports. Now the same organizations lobby the Court with the same policy arguments. Regardless of their merit, they are properly directed at Congress and/or state legislatures, not the Court.

[27] Contrary to U.S. Br. at 19 n.11, Congress did not enact the ADA against a reasoned judicial consensus that HIV is always a disability. The cited cases are AIDS cases, e.g, *Cain v. Hyatt*; cases of substantial limitations of major life activities, *e.g.*, *Thomas v. Atascadero Unified Sch. Dist.*; and dicta citing an AIDS case, *Doe v. Garrett*. Moreover, the Court had expressly reserved the issue in *Arline*, which holds that persons with contagious diseases may be disabled, not that they are always disabled.

V. "MAJOR LIFE ACTIVITIES" HAS NO HELPFUL PLAIN OR ORDINARY MEANING.

Dr. Bragdon has been able to locate only two instances of the phrase "major life activity" or "major life activities" appearing outside a piece about the ADA definition of disability. Both were medical articles. Each equated "major life activity" with school, work, retirement, or keeping house.[28] Furthermore, ask a person unfamiliar with the ADA to list major life activities, and it is as likely he will answer "avoiding pain and seeking pleasure," "war and destruction," "the search for meaning," "gambling, drinking, and womanizing," or "culture and religion," as "seeing and breathing."[29] The "plain meaning" approach is therefore unhelpful or hopelessly over-inclusive.

"Major life activities" only makes sense as a term-of-art chosen to help circumscribe the meaning of "disability" for the purposes of the ADA. Reproduction, regardless of how vital it is to life, does not fit those purposes. That is why

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[28] Evans, et al., *The Quality of Life of Hemodialysis Recipients Treated With [rHuEPO]*, 263 JAMA 825, table 7 (1990); Lee Cohen, et al., *A Reevaluation of Risk of In Utero Exposure to Lithium*, 271 JAMA 146, 149 (1994) (indirectly citing Policy Research Inc., *Medical Practice Information Demonstration Project* at 4, 26 (Gov. Contract No. 282-77-0068 with HEW)).

[29] The same person is as likely to insist that reproduction is a major life event, not a major life activity.

reproduction is not found on HEW's or any other agency's list of major life activities. It is also why not a single comment of over 1,100 received during Justice Department rulemaking maintained that sexual activity and reproduction should be on the Justice Department's list of major life activities, was concerned they were not, or spoke on behalf of the problems of infertility or impotence.[30]

Furthermore, if reproduction (or whatever bundle of activities it refers to) is a "major life activity" because of its importance in life or to life, then nurturing others, feeding and clothing others, having relations with others (or whatever you want to call it) must in principle also be "major life activities" since they are just as vital to the life and growth of children (and the human race) as the bare acts of impregnation and giving birth. But given the extraordinarily broad definition of "impairment," if these forms of other-directed activities are also "major life activities," there *will* be the proverbial flood of litigation, and the ADA will expand into territories presently unimaginable. This is why "caring for others" has never been on any agency's list of major life activities.[31]

Also, contrary to Resp't Br. at 20 n.24 and U.S. Br. at 13, there is no one-to-one correspondence between the list of eleven "body systems" found in the regulatory definition of "impairment," 28 C.F.R. § 36.104, and "major life activities." Some body systems (e.g., skin, cardiovascular) have no corresponding major life

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30 ADA Comment Books #1 and #2 for Public Inspection (comments 100-1299). *See supra* note 12.

31 Construing "major life activities" to include *other-directed* activities is contrary to the impetus behind the ADA, which was to promote independent living. *See* National Council on the Handicapped, *On the Threshold of Independence* (1988) and *Toward Independence* (1986).

activity, and some major life activities (working, caring for one's self) have no corresponding body system. The inclusion of the reproductive system in the list of body systems means that if a woman, for example, is substantially limited in her ability to work because of incapacitating pain associated with dysmenorrhea or endometriosis, or has a record of substantial limitation due to ovarian cancer, she is not excluded from the definition of disability because the condition originates in her reproductive system.[32]

CONCLUSION

While Abbott makes many policy arguments, the better legal arguments support Dr. Bragdon's position. The judgment of the Court of Appeals should therefore be reversed.

Respectfully submitted,

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32 Contrary to U.S. Br. at 10 n.3, no *Chevron* deference is appropriate because Congress did not delegate authority to an agency "to make specific policy determinations," *ABF Freight System v. NLRB*, 510 U.S. 317, 324 (1994); *see Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 696-697 (1991), concerning the meaning of "disability," and the Justice Department has no special expertise to apply, *see PBGC v. LTV Corp.*, 496 U.S. 633, 651-652 (1990).

KNOWLEDGE MAY BE HELD LIABLE FOR CIVIL RIGHTS VIOLATIONS WITHOUT A TRIAL.

A. Dr. Bragdon Made a Reasonable Judgment, Based on Then-Current Medical Knowledge, that Filling Ms. Abbott's Cavity in His Office Would Have Posed a Direct Threat to the Health or Safety of Others.

The following sampling of facts in the record illustrate that, for purposes of summary judgment review, Dr. Bragdon raised a genuine issue of fact under 28 C.F.R. § 36.208(c), as to whether he made an objectively reasonable judgment, based on then-current medical knowledge, that filling Ms. Abbott's cavity in his office on September 16, 1994, would have posed a direct threat to the health or safety of others.[12]

1. In 1991, the Occupational Safety and Health Administration (OSHA) promulgated its Final Standard for Occupational Exposure to Bloodborne Pathogens, 56 Fed. Reg. 64004 (Dec. 6, 1991). These standards apply to dentists. See American Dental Ass'n v. Martin, 984 F.2d 823 (7th Cir. 1993), cert. denied, 114 S. Ct. 172 (1993). OSHA concluded that dental workers who have occupational exposure to blood or certain body fluids are "at risk" of contracting HIV, and that the rate of HIV infection is low, but "not insignificant." 56 Fed. Reg. at 64032. (81a-82a) OSHA specifically rejected the American Dental Association's contention that OSHA overestimated the occupational risk for dentists. Id. at 64092. (83a-84a) OSHA explained that empirical findings are compatible with a finding of a one in 1,000 risk to dentists of a

12 For purposes of summary judgment review, "the evidence of the nonmovant [i.e., Dr. Bragdon] is to be believed, and all justifiable inferences are to be drawn in his favor." Anderson v. Liberty Lobby, Inc.,477 U.S. 242, 255 (1986). "Credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge, whether he is ruling on a motion for summary judgment or for directed verdict." Id.

fatal illness as a result of occupational exposure to HIV infected blood, and that such a risk has "clearly [been] defined . . . as a significant risk." Id. OSHA therefore requires, and the CDC recommends, the taking of certain "universal precautions" (gloves, masks, handwashing, etc.). They are called "universal" in the sense that they are to be used for all patients, not in the sense that they eliminate the risk to dentists of contracting HIV. In fact, when Senator Daniel Moynihan inquired of the CDC in 1995 as to the efficacy for dentists of taking "universal precautions," the Director of the CDC referred Senator Moynihan to "the two latest articles" on the subject. (85a-86a) The first article concerned only cutaneous exposures to blood, and reported an approximately 50% reduction by taking universal precautions. (225a) The second considered parenteral exposures as well, and concluded that "the implementation of UPs [i.e., universal precautions] should reduce the risk of occupational HIV infection by . . .62%." (89a)

This means that according to OSHA, evidence indicates that Dr. Bragdon and his assistants have a significant risk of contracting HIV without taking universal precautions. According to the latest studies recognized by the CDC, Dr. Bragdon and his assistants reduce that risk by 62% -- a little over half -- by taking universal precautions. Most reasonable minds would agree that a 62% reduction in a significant risk of contracting HIV still leaves a significant risk. Accordingly, Dr. Bragdon made a reasonable judgment, based on then-current medical knowledge, that the performance of an invasive procedure, such as filling Ms. Abbott's cavity near the gum line, would have posed a direct threat pursuant to 28 C.F.R. § 36.208(c).

2. In 1992, the Food and Drug Administration (FDA) issued recommendations for the prevention of HIV transmission. The FDA recommends a twelve month deferral

period for all potential blood donors "who have had contact with blood and body fluids through percutaneous inoculation (such as injury or accidental needlestick) or through contact with an open wound, non-intact skin, or mucous membrane during the preceding 12 months." (97a, 90a) This means that whenever a dentist has contact with any patient's blood by accidental needlestick or other sharps injury, the FDA, on account of concern for the transmission of HIV, recommends that the dentist not be permitted to donate blood for twelve months, to ensure that blood tests will detect HIV-antibodies if he is infected.**13** It is therefore reasonable to infer that the FDA, like OSHA, thinks there is a significant risk to dentists of contracting HIV when they are exposed to the blood of their patients.

Every time Dr. Bragdon fills a cavity such as Ms. Abbott's, there is a significant opportunity for him to be exposed to his patient's blood. See 56 Fed. Reg. at 64092 (82a) ("Dentists . . . are continually exposed to blood and bloody saliva during almost all dental procedures."). For example, during the injection of local anesthetic, accidental needlestick injuries to Dr. Bragdon occur before, between, and after injections, as a result of unexpected patient movements, such as biting down or flinching. (69a, ¶ 7; 77a-78a; 138a-139a; 176a) One of Ms. Abbott's experts testified that, for dentists, 1.5 accidental needlesticks per 100 injections, is a reasonable approximation. (154a-155a, ¶ 16) A startled patient can cause instruments, such as explorers (the "shepherd's crook" used to examine teeth), to be driven into the bone of the dentist's finger. (77a, ¶ 7; 139a) The CDC reports that during routine dental procedures, "contamination of saliva with blood is predictable [and] trauma to health-care workers' hands is common." MMWR, vol. 37, no. 24, p. 379

13 Blood tests used to determine if someone is HIV-positive actually detect the presence of HIV-antibodies, which typically do not develop until one to six months after infection.

(June 24, 1988). Dr. Bragdon testified that even doing his best to implement universal precautions, he sustains sharps injuries, most of which draw blood, at the rate of several times a week. (99a-100a) In one study, thirty-five percent of dentists reported between two and fifteen sharps injuries per month. (125a) When drilling a cavity near the gum line, it is not unusual for splatters of blood to reach the dentist. (70a, ¶ 9;102a) The drilling process itself creates an aerosol mist of tiny droplets of blood and bloody saliva that drifts up into the face of the dentist. (69a-70a) Consequently, when filling cavities, and performing other so-called "routine" procedures, it is not at all unusual for the blood and mucous membranes of dentists to be exposed to the blood of their patients. (70a, ¶ 12, 72a-74a)

A reasonable inference from the FDA recommendations concerning deferral periods following exposure to a patient's blood, and from the likelihood of Dr. Bragdon being exposed to the blood of a patient when filling a cavity near the gum line, is that there was a direct threat to Dr. Bragdon within the meaning of 28 C.F.R. § 36.208(c).

3. In June 1994, the CDC reported thirty-seven confirmed cases of occupational transmission of HIV to health care workers (including four to non-surgical physicians), and seventy-eight suspected occupational transmissions of HIV to health care workers, including seven suspected occupational transmissions of HIV to dental workers. (104a-107a) The seven suspected occupational transmissions of HIV to dental workers are cases in which it is reasonable to infer that transmission occurred, because the dental workers suffered occupational exposures to HIV-infected blood, and follow-up investigation by the CDC uncovered no non-occupational risk factors for the HIV-infected workers. (105a) In other words, the seven dental workers who were infected with HIV were "investigated and are without identifiable [non-occupational]

behavioral or transfusion risks." (110a n.3; 111a n.3) The CDC does not, however, refer to such cases as "confirmed," because unlike the thirty-seven confirmed cases of occupational transmission of HIV to health care workers, the infected dental workers did not have blood tests done at the time of exposure confirming that they were HIV-negative at that time. (Id.)**14**

Moreover, in the same June 1994 report, the CDC cautioned that its passive surveillance system for documenting occupational transmissions of HIV "most likely does not reflect the full extent of occupational transmissions," and that estimates are that "only 10% to 60% of percutaneous injuries are reported" (emphasis added). (105a) Based on this CDC report, it was reasonable for Dr. Bragdon to conclude that perhaps as many as seventy dental workers, and at least seven, had already suffered occupational transmissions of HIV, and therefore, there would have been a direct threat to him and his staff while performing invasive procedures on Ms. Abbott in his office.

4. In 1991, the CDC reported that a Florida dentist, despite using barrier precautions, transmitted HIV to five of his patients, between 1987 and 1989. (111a-1 - 130a) The routine procedures in question included restorative fillings, prophylaxes, and simple extractions. The CDC explained that

> [a]ll five patients received multiple injections

14 The Appeals Court dismissed the relevance of these seven infected dental workers by playing on the word "possible." Specifically, although the CDC refers to these suspected cases of HIV transmission as "possible" cases, it is obvious from the context of the CDC report that this does not mean "possible" in the sense that "anything is possible." In legal terminology, what the CDC calls "documented" cases, and what the Appeals Court and petitioner call "confirmed" cases, are on the order of "beyond a reasonable doubt," whereas "possible" cases are those in whichthe preponderance of the evidence suggests that occupational transmissions of HIV occurred.

> of local anesthetic, and a sharps injury during anesthetic administration could have resulted in contamination of the syringe apparatus with the dentist's blood. . . . A sharps injury could also result in direct contact of the dentist's blood with the patient's inflamed or nonintact oral tissues during the invasive procedures. Although the dentist began to routinely wear gloves in 1987, gloves do not prevent most injuries caused by sharp instruments.

(126a)

The CDC updated this study in 1993, and concluded that a sixth patient was also infected with HIV while receiving care from this dentist. Unlike the other patients, "this patient had neither dental extractions nor root canal therapy." (132a) Other than X-rays and a cleaning, there was only a single surface restorative filling (131a), just like the "routine procedure" at issue in this case.

In addition, experts agree that the risk of transmission of HIV from patient to dentist is greater than the risk of transmission of HIV from dentist to patient. For example, Dr. Molinari's article in the October 1993 issue of the Journal of the American Dental Association reports: "The risk of transmitting HIV from patient to HCW [health care worker] is much higher than the risk of transmitting from HCW to patient." (137a) Dr. Molinari later reiterated his view that "the danger is much greater for dentists and dental care workers than it is for patients" (emphasis added). (139a)

Given the documented transmissions of HIV from dentist to patients while filling a simple cavity and other "routine procedures," given that courts are in agreement that there is a direct threat to patients from HIV infected health

care workers, including dentists,15 and given experts' opinion that the risk to dentists is much greater than the risk to patients, it was again reasonable for Dr. Bragdon, or anyone else, to conclude that filling Ms. Abbott's cavity near the gum line would have posed a direct threat to him and his staff.

5. Dr. Bragdon also introduced as evidence an affidavit from Leon Kelleher, D.D.S. Dr. Kelleher directs a group of seventeen dentists who treat over 100 HIV-positive patients in the Chicago area. Dr. Kelleher testified that their "standard operating procedure is to avoid the use of aerosol producing instrumentation [i.e., the dentist's high speed drill] in known HIV+ cases." (140a, 143a) According to Dr. Kelleher, "[p]atients on whom the use of the high speed handpiece [i.e., the drill] is unavoidable are done with high volume evacuation under laminar flow conditions with hood or full face protection and remote air source for the operator." (143a) Dr. Kelleher's group adopted its protocols because of the results of a 1991 study conducted by Drs. Johnson and Robinson at Stanford University School of Medicine. (Id.) Drs. Johnson and Robinson reported that infectious HIV can be isolated from aerosols generated from HIV infected blood, and concluded that

> dentists . . . should avoid techniques which generate such aerosols . . . with patients known to be infected with HIV. Where such procedures are unavoidable, personnel should consider using high efficiency filtration masks and systems for containing aerosols.

(149a)

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15 E.g., Bradley v. Universtiy of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993), cert. denied, 114 S. Ct. 1071 (1994); Mauro v. Borgess Medical Ctr., 886 F. Supp. 1349 (W.D. Mich. 1995); Doe v. Washington Univ., 780 F. Supp. 628 (E.D. Mo. 1991).

Rather than filling Ms. Abbott's cavity in his one-dentist office in the outskirts of Bangor, where such high efficiency filtration devices are not available, Dr. Bragdon wanted to defer treatment to a local hospital setting, where he had reason to believe they were available. (101a) This was a reasonable judgment by a health care professional. Yet, without a trial, and despite conflicting expert affidavit's (150a-159a), two courts have now determined as a matter of law that Dr. Bragdon unlawfully discriminated against Ms. Abbott. Now pending in District Court is Ms. Abbott's application as a prevailing party for attorneys fees and litigation expenses in the amount of $205,190.63. The fact that Dr. Bragdon may owe over $200,000 for wanting to take the same precautions as are routinely taken by dentists in big cities, and that federal courts are in effect compelling him to take risks at work that other dentists routinely do not, is truly Orwellian, and deserving of this Court's attention.

6. In affirming the summary judgment against Dr. Bragdon, the Appeals Court held that all of the evidence presented by Dr. Bragdon, taken individually and cumulatively,16 did not raise a genuine issue for trial. The

16 Dr. Bragdon presented other compelling evidence as well. For example, he presented the direct affidavit testimony of Sanford F. Kuvin, M.S., M.D., D.T.M. & H. Dr. Kuvin, whose qualifications under Rule 702 as an expert witness on infectious diseases were not challenged , corroborated the sources of information already discussed, and concluded that there would have been a direct threat to Dr. Bragdon. (150a-160a) Dr. Kuvin also testified that according to CDC recommendations regarding the danger of tuberculosis ("TB"), dentists should decline to perform aerosol-generating procedures on an HIV-positive patient without high-efficiency particulate air filtration that was unavailable to Dr. Bragdon in his office. (152a-154a) Using a form of analysis recognized by the Fourth Circuit in Doe v. University of Md. Medical Sys. Corp., 50 F.3d 1261 (4th Cir. 1995), and empirical data available to Dr. Bragdon in 1994, Dr. Kuvin further testified that a conservative estimate of the risk that a dentist will receive at least one fatal, accidental needlestick, during 30 years of practice giving approximately one injection per working day to an HIV infected patient, is one in ten. (154a-156a) For

Appeals Court arrived at this result, ostensibly, by attaching a continuing presumption of correctness to the conclusions that it thought were implicit in the 1993 Guidelines. This is what the 1993 Guidelines actually say:

> This document updates previously published CDC recommendations for infection-control practices for dentistry (1-3) and offers guidance for reducing the risks of disease transmission among dental health-care workers (DHCWs) and their patients. . . .
>
> . . .
>
> A set of infection-control strategies common to all health care delivery settings should reduce the risk of transmission of infectious diseases caused by bloodborne pathogens such as HBV and HIV. . . .
>
> . . .
>
> For both HBV and HIV, the precise event or events resulting in transmission of infection in the dental setting have not been determined; . . .
>
> . . .
>
> Additional information is needed for accurate assessment of factors that may increase the risk for transmission of bloodborne pathogens and other infectious agents in a dental setting.

(182a, 183a, 184a, 199a)

The Court will search in vain in the 1993 Guidelines (181a-199a) for any more definitive statement of the significance of the risk to dentists, or of the rationality or

the sake of comparison, the risk of sustaining a fatal, accidental needlestick, while giving just one injection to an HIV infected patient, is slightly greater than the risk of having a fatal parachute accident while skydiving. (161a-162a, 164a, 165a-166a)

legality of taking additional precautions while working on persons known to be HIV positive. In fact, although the plaintiffs vaunt the significance of the 1993 Guidelines, they did not cite in their appellate briefs a single word from that document. Nor, apart from two references in the United States' brief to a 1993 CDC article about the risk of occupational infection in operating and delivery room settings (also cited by Dr. Bragdon in his brief), did the United States, Ms. Abbott, or any of their health department amici, cite a single word from any published CDC source, or even a single word from any of their own published sources.

The outcome of this case was therefore determined by the application of an extraordinarily unusual standard of review at summary judgment, and not by the failure of Dr. Bragdon to present evidence, including direct expert witness testimony,**17** that would have otherwise entitled him to a trial under normal summary judgment principles. Cf. Doe v. Johnston, 476 N.W.2d 28, 31 (Iowa 1991) (materiality of risk was properly a jury question when conflicting expert testimony put risk of contracting HIV between 1/100,000 and 1/1,000,000); cf. also Carter v. Temple-Inland Forest Products Corp., 943 S.W.2d 221 (Tex. App. 1997) (reasonableness of party's fear of developing cancer was properly a jury question when the evidence was that the risk of developing cancer was between 1/100 to 1/500,000).**18**

B. Ironically, Dr. Bragdon, More Than Ms. Abbott,

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17 See note 16 supra.

18 Another clear indication that Dr. Bragdon would have survived summary judgment on normal summary judgment principles, is that while the Appeals Court did its best to discount, ignore, and belittle the evidence presented by Dr. Bragdon, it did not indicate that the outcome would have been the same under a standard of review more favorable to him. In light of how narrowly the Appeals Court attempted to write on the issue of direct threat, the Appeals Court surely would have added such a proviso if it thought it were true.

Must Confront Myth and Prejudice in this Case.

It is sometimes assumed that among the poorly educated, there is an irrational fear and prejudice that HIV is easily transmitted. Whether or not this is true, there is most certainly a myth and prejudice among the well educated, including those like ourselves who have had friends or relatives become infected with HIV or die of AIDS. The myth is that apart from activities like unprotected sex and sharing dirty needles, science has shown that the risk of transmission of HIV to be nil, even for dentists working with sharp instruments in bloody mouths. The prejudice is that dentists or doctors who think otherwise, or who want to take significant additional precautions when working with even small amounts of HIV infected blood, must be ignorant, homophobic, stigmatizing, cowardly. unethical, and/or uncaring.

This myth and this prejudice is perfectly exemplified by a recent cover story on this case in the American Bar Association Journal, in which the author assumes and/or implies for his audience that there is clear scientific evidence of no significant risk to dentists. He writes:

> Although the evidence is to the contrary, dentists may perceive greater risks of contracting HIV by coming into contact with a patient's blood. A typical dental examination is a more invasive procedure than a routine physical exam and often draws blood, even during routine cleaning.

(207a - emphasis added) The author, of course, does not explain what is the "evidence to the contrary," or in what medical journal or CDC publication it can be found.

The vital point for the Court to understand is that no-where in the record has the CDC, any of Ms. Abbott's four experts, or any of the many amici public health organizations, been able to point to a single, scientific, reasoned analysis that was available to Dr. Bragdon, concluding that the risk to a dentist filling a cavity (or performing other procedures which routinely draw patients' blood) is insignificant, or that because of a crisis in the availability or cost of dental care for HIV-infected individuals, dentists must be compelled by federal law to perform invasive procedures in their offices on patients known to be infected with HIV, without taking significant precautions beyond those recommended by the CDC for all patients. There is no such analysis. It is a myth that there is, and this myth serves a political agenda, just as much as the myth that AIDS is a gay disease serves a differing political agenda.[19]

Ms. Abbott herself plays upon this myth by repeatedly making the fallacious argument that the risk to dentists is nil because, except for the seven suspected transmissions of HIV to dental workers documented by the CDC, and the six transmissions to dental patients also documented by the CDC, the CDC has never documented another case of HIV transmission in the estimated over "one billion dental procedures" performed by "250,000 other dentists" in this country in "the last fourteen years." (Appellee's Br. at 8)

But what kind of argument is this, when people can be

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19 The morally righteous tone to the plaintiffs' political agenda is illustrated by the response of one of Ms. Abbott's experts to the question of whether Dr. Bragdon should be legally compelled to treat HIV-infected patients, assuming there is a substantial likelihood of a transmission of HIV to him or his staff once every 10 years, or even once every year. His answer was "Yes," "Life is a risk," "[T]here's obviously a risk, and I think he should provide services. I'm not saying when you provide services you provide it risk free and nothing happens. So the time frame makes no difference to me." (170a-171a)

HIV-positive for many years without knowing it, and the CDC admits that its passive surveillance system for documenting HIV transmissions to dentists underreports by as much as 90%? (105a)

Scientifically, the argument is specious, but rhetorically, it helps reinforce the myth that it is nigh unto impossible to transmit HIV, outside of unprotected sex and dirty needles. The truth is, however, a little drop of blood on an open wound or mucous membrane can transmit HIV, although in light of the cruelty of many in society to those with HIV, we prefer to ignore it.**20** But this does not mean that the government ought to be in the business of compelling private health care providers to act against their reasonable judgments, even if reasonable health care providers disagree about the significance of a risk.

C. The Appeals Court's Decision Sets a Very Bad Precedent that Will Have Deleterious Effects On Efforts to Build an Improved, Coherent Administrative System for the Regulation of Small But Significant Health Risks.

An expert in administrative law recently observed that "serious problems currently plague efforts to regulate small, but significant, risks to our health." Stephen Breyer, Breaking the Vicious Circle, 10 (Harvard Univ. Press 1993). The Appeals Court's opinion, if left to stand as law, will exacerbate those problems.

More precisely, this case is being watched carefully by state and national public health agencies and health care providers (180a), including, of course, the many national and state agencies and associations that filed amicus briefs in the

20 The CDC reports that "visible blood on device" is a significant factor for increasing the risk of HIV infection for a health-care worker following a percutaneous injury. MMWR, vol. 44, no. 50, p. 929-932 (Dec. 22, 1995).